Personal Medication Record

SeniorNavigator.org – Virginia's Resource for Health and Aging

Name: Sex:

Address:

Social Security #: DOB:

Emergency Contacts

Name: Hm Phone:

Address: Wk Phone:

Name: Hm Phone:

Address: Wk Phone:

Primary Care Physician: Phone:

Specialist: Phone:

Medications (Including over the counter and herbals):

Medication:	Dosage:	Frequency:
1.		
2.		
3.		
4.		
5.		
6.		

Blood Type:

Recent Surgeries: Date:

1.

2.

3.

Religion:

Living Will on file at:

Do you have a Comfort Care/DNR form?

Where is it located?

Medical Conditions:

Check all that apply and specify below, if applicable.

( ) No Known Medical Conditions
( ) Abnormal EKG
( ) Adrenal Insufficiency
( ) Alzheimer's Disease/Dementia
( ) Angina
( ) Anemia
( ) Asthma
( ) Bleeding Disorder
( ) Cataracts
( ) Coronary Bypass Graft
( ) Diabetes
( ) Dialysis
( ) Glaucoma
( ) Hearing Impaired
( ) Heart Attack
( ) Heart Valve Prosthesis
( ) High Blood Pressure
( ) High Cholesterol
( ) Leukemia
( ) Low Blood Sugar
( ) Lymphomas
( ) Pacemaker
( ) Renal Failure
( ) Seizure Disorder
( ) Stroke
( ) Thyroid Disorder
( ) Vision Impaired
( ) Other (List Below)

1. _____
2. _____
3. _____

Allergies:

( ) No Known Allergies
( ) Aspirin
( ) Codeine
( ) Environmental
( ) Latex
( ) Lidocaine
( ) Penicillin
( ) Sulfa
( ) X-Ray Dyes
( ) Other (List Below)

1. _____
2. _____
3. _____

Medical Insurance:

Medical Insurance Company _____
Policy # _____
Other Medical Insurance _____
Medicaid # _____
Medicare # _____

Personal Medication Record

Name: Sex:

Address:

Social Security #: DOB:

Emergency Contacts

Name: Hm Phone:

Address: Wk Phone:

Name: Hm Phone:

Address: Wk Phone:

Primary Care Physician: Phone:

Specialist: Phone:

Medications (Including over the counter and herbals):

Medication:	Dosage:	Frequency:
1.		
2.		
3.		
4.		
5.		
6.		